DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

454 5/23/15

04/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445343	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT SOUTH PITTSBURG, THE	201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380

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F 000	INITIAL COMMENTS During an annual recertification and complaint investigations #35443, #35506, #35631, #35863, and #35864 conducted on 4/6/15-4/8/15, at The Bridge at South Pittsburg, no deficiencies were cited in relation to the complaints under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	**Disclaimer:** The Bridge at South Pittsburg does not believe and does not admit that any deficiencies existed either before, during, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to its residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157 Notify of Changes (Injury / Decline / Room, etc)** The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving	5/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ADM — ADMINISTRATOR — 4/30/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigations, and interview, the facility failed to notify a family member after a fall for one resident (#56) of four residents reviewed of thirty-nine sampled residents. The findings included: Review of the facility policy titled Fall Policy dated April 2012, revealed "...if fall occurs the following actions will be taken...e. Notify physician and family..." Medical record review revealed Resident #56 was admitted to the facility on 10/8/12 with diagnoses including Alzheimer's Disease, Hypertension, Chronic Kidney Disease Stage 2, Generalized Anxiety, Mood Disorder, Depressive Disorder, Psychosis, Difficulty Walking and Personal History of Falls. Medical record review of the quarterly Minimum Data Set (MDS) dated 3/30/15 revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS), indicating the resident was moderately cognitively impaired, was only able to stabilize with staff assistance, and walked in room with one person physical assist. Review of a facility investigation for Resident #56 dated 3/24/15 revealed, "...On patients return to	F 157	the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e. physical, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 473.12(a). The facility will also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The Facility will record and periodically update the address and phone number of the resident's legal representative or interested family member. **Residents Affected:** On 04/28/15, DON notified legal representative (conservator) of Resident #56's fall that occurred 3/24/15 .	

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F 157	Continued From page 2 bed, she fell in the floor. This nurse found resident in floor on abdomen resting on her left arm. Range of motion and full body assessment completed and within normal limits. Vital signs stable. When asked about occurrence resident replied, 'I just fell. Period'. Nurse x2 [two nurses] assisted patient to sitting position and then continued transfer from floor to bed...No injuries noted...Notifications and orders doctor: NP [Nurse Practitioner]-3/24/2015 7:20 am...Orders received: NP- 3/24/2015 7:20 am..." Interview with Director of Nursing (DON) on 4/8/15 at 9:46 AM, in the conference room, confirmed there was no documentation in the Nursing Assessment, Fall Investigation, or Nursing Notes regarding family notification after the fall, and the facility failed to follow policy for notification of family.	F 157	**Residents Potentially Affected:** All residents who have experienced a fall have the potential to be affected by this cited practice. By 5/22/15, DON / UMs will conduct audit of medical record and/or event manager of residents' who have experienced falls within the last 90 days. DON/ UMs will notify responsible parties if indicated based on findings of audit by 5/22/15. **Systemic Measures:** DON/SDC will educate nursing staff (LPN / RN) on facility Fall Policy by 5/22/15. DON/SDC to provide competency test to nursing staff on Fall Policy by 5/22/15. **Monitoring Measures:** Resident falls will be discussed in daily clinical meeting (Mon-Fri) and documentation reviewed by the QA team. Any identified concerns related to notification compliance will be corrected immediately and reported to the Administrator and education will be given until compliance achieved. Compliance issues will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigations, and interview, the facility failed to implement the abuse policy for one resident (#130) of five residents reviewed. The findings included:			

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F 226	Continued From page 3 Review of facility policy titled "Abuse, Neglect, and Misappropriation" most recently revised in March 2013, revealed, "...All allegations of abuse are reported immediately to the charge nurse...The charge nurse will immediately notify the Administrator, DON [Director of Nursing]..." Medical record review revealed Resident #130 was admitted to the facility on 2/21/15 with diagnoses including Dementia with Behavior Disturbance. Medical record review of a Minimum Data Set dated 2/28/15 revealed the resident's Brief Interview of Mental Status score was five, indicating impaired cognitive ability. Review of a facility investigation dated 3/2/15, and signed by Certified Nursing Assistant (CNA) #1, revealed, "...Investigation Regarding: [Resident #130]...Date Incident Occurred: 3-2-2015...I was in the room with [CNA #2]...at 7:30 PM...I went into the room at 9:28 and gave [resident] a clean comforter and [resident] stated...arm was hurting b/c [because] I beat [resident]. Immediately gave [resident] the blanket and told the nurse what was stated..." Review of a facility investigation dated 3/2/15, and signed by Licensed Practical Nurse (LPN) #1, revealed, "CNA [#2] approached me and told me that [resident] was hurting & [and] that [resident] told CNA not to hit [resident] again..." Review of facility investigation dated 3/3/15, and signed by the DON, revealed, "...This morning I received notice that [resident] stated a cna had beaten [resident] up...I reported this	F 226	**F226 Develop / Implement Abuse / Neglect, Etc Policies** The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation. **Residents Affected:** Investigation began by Administrator on 3/3/15 to ensure safety of Resident #130. Alleged CNA was immediately suspended ono 3/3/15 pending outcome of the investigation. Investigation concluded that allegation was unsubstantiated with no adverse effects to resident. LPN#1 provided one-on-one in-service by DON on 3/3/15 on facility Abuse Policy, including reporting requirements. **Residents Potentially Affected:** All residents who have alleged abuse have the potential to be affected by this cited practice. Administrator reviewed all investigations / State Reportables for last 60 days on 4/29/15 with no compliance issues noted. **Systemic Measures:** Administrator / SDC to conduct in-service with staff on facility Abuse Policy by 5/22/15. Administrator or SDC will complete abuse training with all new employees upon hire during orientation prior to assuming position on the floor.	5/22/15

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F 226	Continued From page 4 to...admininstrator..." Interview with the DON on 4/7/15 at 4:28 PM, in the therapy room, revealed the DON was not immediately notified of the resident's allegations and confirmed the facility failed to implement the abuse policy for Resident #130.	F 226	**Monitoring Measures:** Abuse investigations will be discussed daily (Mon-Fri) in morning Clinical Meeting and reviewed by QA team to ensure compliance with Abuse Policy. Any noted compliance issues will be addressed accordingly at that time and forwarded to the QA committee. Any identified concerns related to compliance with facility Abuse Policy will be addressed immediately and reported to the Administrator. Concerns will be addressed in monthly QA meeting x 3 months for recommendations and further follow-up as indicated.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow a physician's order for one resident (#43) of thirty-nine sampled residents. The findings included: Medical record review revealed Resident #43 was admitted to the facility on 1/1/15 with diagnoses including Alzheimer's Disease and Lower Extremity Edema. Medical record review of a physician's order dated 1/1/15 revealed, "PT/OT/ST to eval and tx [Physical Therapy/Occupational Therapy/Speech Therapy to evaluate and treat]." Medical record review revealed the resident was treated by PT and OT and discharged home on 3/9/15. Continued review revealed no documentation regarding Speech Therapy.	F 281	**F281 – Services Provided Meet Professional Standards** The services provided or arranged by the facility will meet professional standards of quality. **Residents Affected:** No changes can be made to Resident #43 due to discharging home on 3/9/15. **Residents Potentially Affected:** All residents with order for Speech Therapy have the potential to be affected by this cited practice related to professional standards. DON / UMs / RSM to audit speech therapy orders for residents admitted in the past 90 days by 5/22/15. DON / UMs / RSM to address issues found during audit as indicated.	5/22/15

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F 281	Continued From page 6 Interview with a corporate nurse on 4/8/15, at 11:05 AM, in the conference room, revealed the facility was unable to provide documentation regarding a Speech Therapy evaluation and confirmed the facility failed to follow the physician's order for Resident #43.	F 281	**Systemic Measures:** Regional Therapy Director to conduct in-service with therapists by 5/22/15 on following physician orders for evaluations and treatment. **Monitoring Measures:** DON / UMs / RSM to conduct random audit monthly x 3 months to monitor compliance with physician orders. Therapy orders will be brought to daily Clinical Meeting (Mon-Fri) and communicated to Rehab Manager as they are written. Any identified concerns related to following of physician orders will be corrected immediately and reported to the Administrator. Concerns will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to maintain a complete medical record for one resident (#13) of thirty-nine sampled residents. The findings included: Review of facility policy titled "Chart Order - Closed Records" dated March 2013, revealed, "...Assembling the medical record shall be completed at the time of discharge or death...Health Information Management Director	F 514	**F514 – Res Records – Complete /Accurate/ Accessible** The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record will contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	5/22/15 pr telephone C McNee 5/22/15 1:45pm JM

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F 514	Continued From page 6 shall be responsible for...arranging the medical record for final disposition...Health information shall file a written report with the administrator of any incomplete closed record...Medical records shall be...completed within thirty (30) days of discharge..." Medical record review revealed Resident #13 was admitted to the facility on 1/30/15 with diagnoses including Alzheimer's Dementia. Medical record review of a physician's order dated 2/23/15 revealed, "DNR [Do Not Resuscitate] Palliative Measures." Medical record review of a nurse's note dated 2/24/15 at 4:10 PM, revealed, "no spontaneous VS [vital signs]...family request body be released..." Medical record review of a Discharge Summary dated 2/24/15 revealed the resident expired on 2/24/15. Continued review revealed the interdisciplinary summaries regarding the resident's stay were blank. Interview with the Director of Medical Records on 4/8/15 at 1:42 PM, in the corridor outside the conference room, confirmed the facility failed to maintain a complete medical record for Resident #13.	F 514	**Residents Affected:** No changes can be made to Resident #13's medical record due to resident expiring on 2/24/15. **Residents Potentially Affected:** All residents who have discharged from the facility have the potential to be affected by this cited practice. DON/ UMs will audit all discharge summaries from the last 90 days by 5/22/15 for completeness and accuracy. DON / UMs to address issues found during audit as indicated. **Systemic Measures:** DON or Administrator to In-service Interdisciplinary Team by 5/22/15 on facility Medical Record Policy for accuracy and completion of discharge summaries. **Monitoring Measures:** Discharge summaries will be brought to daily Clinical Meeting (Mon-Fri) for review and completion. Any identified concerns related to completeness of medical records will be corrected immediately, reported to the Administrator and education completed until compliance is achieved. Concerns will be addressed in monthly QA x 3 months for recommendations and further follow up was indicated.	